Editorials

Physician-Subsidized Health Care

ELSEWHERE IN THIS ISSUE an admittedly less than perfect study provides some insight into the extent to which physicians, at least in San Francisco, think they are subsidizing health care in their community. Even if the figures are substantially overstated and by a self-selected segment of the physician population in San Francisco, they are impressive. They also suggest how far we have drifted from the loudly proclaimed social goal of the 1960s, which was to eliminate "demeaning" charity from patient care. Charity in health care has continued to be with us. No one thinks that it was ever completely eliminated.

In any case, these are the 1980s, soon to be the 1990s, and the resources for needed charity are coming under severe strain. The social programs that were expected to eliminate "demeaning" charity and assure dignity in health care regardless of the ability to pay have simply failed to do this. More and more of the third-party payers in both the public and private sectors are either unwilling or unable to pay the true costs of patient care. Paradoxically, the human and technologic resources for health care exist in relative abundance—certainly this is true in San Francisco—but there are not sufficient dollars to pay for care that is presently uncompensated yet needed. The burden of taking care of those who cannot pay the real costs is being carried by the charity that community hospitals, practicing physicians, and others in the health care field are willing and fiscally able to provide. It seems more and more evident that the fiscal capacity for this charity is limited and may soon be exceeded by the need for it.

There are recognizable, inescapable basic costs to rendering uncompensated care, and if these costs cannot somehow be met, there will be no uncompensated care, no matter how good the intentions are of those who would want to provide it. The fiscal squeeze has been on hospitals, physicians, and local communities for some time now, and in certain programs for the needy the costs of rendering care have already begun to exceed the revenues available to pay those costs. The fat is now pretty well out of the system, and there are signs that the bone and the muscle are beginning to be cut away.

As one ponders this prospect of inadequate or unavailable health care for those who may need it most, one wonders if a way might be found to make whatever dollars are available for indigent care more readily available to be used more efficiently where the care is needed—that is, in the local communities or perhaps in some kind of community-based health care regions, possibly under the jurisdiction of a community or regional authority that would be relatively free of inefficient and costly interference and restriction from state and federal governments. As it is, the sources of the dollars are all far from the real human action in health care. Federal and state programs have now been shown not to meet the need. Perhaps their administration and control have been just too remote to be able to function efficiently and effectively at a local level, where health care dollars could be applied in response to human needs and within a framework of human relationships. Maybe it is time to streamline the system and give decentralized local communities and health care regions more of the financial resources and more responsibility for how they are spent, and thus allow them a better chance of solving their own problems in what might prove to be more sensitive ways.

MSMW

Medicare Payment Reform—A Practitioner's Perspective

AS THE PHYSICIAN PAYMENT REVIEW COMMISSION attempts to find ways to restructure Medicare financing for physicians' services, the perceptions of practicing physicians and the way in which they are paid for the work they do tend to vary with their specialty. All parties have many axes to grind. Consequently, Lee and Ginsburg have their work cut out for them if they are to truly build a consensus on the Medicare payment reform they discuss elsewhere in this issue.

Questions of physician payment tend to arouse powerful emotions within and outside of medicine. It is sobering to think that in the last months of 1987, underpaid physicians in Peru struck for higher wages and were teargassed after throwing rocks during a clash with the police. In several countries there are physicians who cannot find a job or who must move to remote areas in order to earn a living wage.

Physicians in the United States have been lucky, but, then again, so have many other Americans. The 1987 average remuneration (salary and fringe benefits) for industrial workers in this country reached $50,000 a year. The average physician now earns more than double that amount. But the average primary care physician does not.

Medicare has been a major contributor to physicians' incomes. In retrospect, the opposition of the American Medical Association to the creation of Medicare seems extraordinary. Few, if any, other "industries" would have rejected such largess, especially since the burden of charitable care had also been removed with the creation of Medicaid. The much-feared concurrent government regulation has also been much slower in coming than many would have predicted.

The climate in which medicine is practiced has changed. The 1965 blend of charitable and fee-for-service care has yielded to the 1988 fixation on the bottom line. There is more money but less honor in medicine. And there are nearly 40 million Americans without any health insurance. At the same time, the approach toward physicians has changed. We are increasingly being viewed as economic animals to be manipulated into compliance by each and every program of the moment: from healer to puppet in a little more than 20 years.

Medicare sends confusing signals. There is more pay for a home visit by a nurse than by a physician. Chiropractic adjustments constituted the ninth most common service paid by Medicare in 1983—procedures for which there is public demand but with little in the way of agreement regarding necessity, utility, or quality. Preventive medicine is not covered by Medicare, but the National Institutes of Health continue to promote it vigorously.

Fee-for-service practice is now burdened with administrative requirements that force an increasing amount of both physician and staff time to be directed away from patient care. Examples are the explanation of maximum allowable actual

charges and compulsory lab assignment and the latest requirement that a clinician anticipate what Medicare may not pay for (or how much it will pay if it does pay) and refund any money collected unless a signed agreement to pay has been obtained in advance—in a form that has yet to be described.

These are admittedly small items in the grand scheme of health care financing, but they threaten to wreck the everyday practice of medicine. There is reason to think that the government has become less interested in enticing more physicians into becoming participating physicians and accepting assignment for all Medicare patients. Instead, there is now a heavy-handed effort to coerce physicians into doing so by making life unbearable for those who do not.

The frustration of costly and time-consuming administration and of coping with downgraded and disallowed services undoubtedly is a contributor to the higher volume of billed services per recipient that has recently been noted. It also threatens to produce a numbing conformity as it rapidly becomes apparent that anything falling outside the computer screens will lead to an involved explanation and perhaps an accusation of performing "unnecessary" services. Thus, it may be more prudent to admit to hospital a patient needing a second electrocardiogram within a 30-day period than to obtain one in the office. Similarly, it makes some kind of sense to send a patient with pulmonary edema to an emergency department to receive intravenous furosemide rather than administer it in the office. The latter technique has been turned down for payment on the grounds that it is not covered on the same day as an office visit. These are actual events. There seems to be no recognition that extra services may be needed to avoid even more costly care, or, if there is recognition, the question is ignored because it is so hard to evaluate the circumstances quickly.

The Physician Payment Review Commission considers that fee-for-service medicine will continue to play an important role in the future. Indeed, the commission has resisted some administration proposals that would sharply decrease the role of fee-for-service: for example, Medicare preferred provider organizations and the conversion of corporate retired employee benefit plans into capitated programs known as MIGs (Medicare insured groups). The commission's attitude toward the "cognitive-procedural" question is not entirely known at this time. For the moment, Congress, in the 1987 budget act, called for preferential treatment for office, home, and nursing home visits. Lee has endorsed this position by suggesting the annual Medicare update be allowed for these services but deferred for all other services at the present time.

On the other hand, Ginsburg pointed out in an interview (*The Internist,* May-June 1987, p 23) that should there be substantially inequitable underpayments for some widely used services, such as office visits, satisfactorily redressing such an inequity would require large decreases in the reimbursement for other services to generate the necessary funds. This assessment would seem to validate the long-held view of some "procedural" specialists that any increase in "nonprocedural" fees would only come entirely at their expense. Concerned about just such a possibility, the American College of Radiology cut its own fee deal with Congress last year. The entire issue is potentially highly divisive, and one prominent commentator has suggested that quarrels over physicians' incomes may lead to an important decline in the current political power of physicians (*The Wall Street Journal,* February 9, 1988, p 30).

Another source of difficulty with consensus—if the term is intended to include the medical profession—comes from the repeated statement that proposed changes must be both budget-neutral and also protect beneficiaries against increased out-of-pocket expense. This, of course, is the congressional mandate to the Physician Payment Review Commission. But in the face of an aging population and increasing technology—much of it cost-raising rather than cost-lowering—and of the undiminished social expectations of medicine, this may prove impossible. By implication, physicians may expect a series of progressive fee cuts when even extraneous factors cause budgetary shortfalls. The reduction of some surgical fees on the basis of "inherent reasonableness" may be the first such exercise. The reason for thinking so is that there is to be a coincident reduction in laboratory reimbursement of approximately 8%, already subject to mandatory assignment, that will have a further negative effect on the economic position of the primary care specialties. Thus, lean cats as well as fat cats are being targeted, and all cats are affected by across-the-board governmental payment cuts such as the Gramm-Rudman-Hollings reductions.

In such a climate, any pressure for mandatory assignment is particularly worrisome. Experience with Medicaid (validated by surveys by the California Medical Association) has shown that physicians are less concerned by lower pay than by arbitrary and unpredictable behavior by fiscal intermediaries. The latter upsets and frustrates office staff and affects overall performance in the care of all patients.

Mandatory assignment also creates a conflict of interest between physicians and patients. Under nonassigned billing, a patient suffers extra out-of-pocket expense when Medicare reimbursement is deficient. In the case of assigned claims, the patient has no balance due should Medicare fail to pay the physician for a legitimate service. Should Medicare underpay the physician, the 20% balance due from the patient will be less than if the proper fee were recognized. Thus, under mandatory assignment, the patient is either insulated from the question of how physicians are paid or has a bias toward lower levels of compensation.

This discussion has so far not acknowledged that there is a problem with both overcharging and billing for unnecessary services. These are the Achilles' heel of fee-for-service medicine, and they must be stopped. At the same time, the fee-for-service segment of health care is the one with the greatest incentive to please patients and to innovate. Despite its shortcomings, it serves a vital role as a counterpoise to managed care and capitated plans, which would have less incentive to provide a maximum level of care were it not for competition from the fee-for-service segment. Thus, I think fee-for-service medicine needs both supervision *and* protection. Administering it into oblivion will be counterproductive.

Certain factors indirectly bear strongly on physician reimbursement. I am especially concerned that 70% of Medicare payments go to 9% of the insured, that care in the last year of life consumes up to half of all Medicare funds, and that terminal illnesses consume a third. At the same time, preventive medicine is excluded. These figures suggest a gross distortion of policy that must, of necessity, distort physician reimbursement.

Better funding of Medicare would allow more flexibility in designing ways to pay physicians. It seems incongruous

that many patients older than 65 are well-to-do, yet are "protected" against physicians by mandatory fee freezes and service restrictions. In the aggregate, the 65-plus decade is the second wealthiest in the nation. Nevertheless, this group does not share in paying for inflationary increases in a physician's cost of doing business, leaving these increases to be passed on to younger people, who are often less affluent. It is not even clear that it is legal to treat people of Medicare age *outside* the Medicare program. The current attempt to lump the care of all senior citizens, regardless of personal resources or attitude toward health care, into a uniform mold promises to backfire badly should this continue as a key element in health policy.

Some form of tiered care may be the only satisfactory answer. In Britain and Canada, with their much-acclaimed but monolithic systems, there are increasing complaints of poor and delayed service, underfunding, and misallocation of resources. It simply seems foolish to head directly along the same course in the United States.

Primary care may require entirely new approaches if it is to remain viable and keep its practitioners from lobbying for direct employment by the federal government. One such method might be to partially capitate care to provide a financial base and then pay relatively modest supplements for actual services rendered. Patient co-payments would be needed to balance the incentives.

If the entire Medicare program is to remain solvent, it also would seem wise to attempt to recoup some of the money spent on terminal care. This might even be used as a start toward paying for more long-term care, a subject of great current interest to the American Association of Retired Persons. In the case of the affluent elderly who leave no surviving dependents, there seems little reason not to have the government, through a lien on the estate, attempt to recoup at least a part of the funds spent on terminal care. Safeguarding estates at the expense of the public hardly seems like sound social policy.

There must be innumerable ideas for improving Medicare. Not all will be the product of consensus panels. Though this technique has a sound social and political basis, its use in policy-making in clinical areas should remind us that it will not automatically bring forth the most effective or innovative approaches.

Lee and Ginsburg put it well when they say, "One central challenge . . . is to find a way to incorporate society's concerns about limited resources into physicians' decision making while maintaining the physician's freedom and responsibility to exercise clinical judgment on behalf of the patient."

Amen.

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Further Comments on Chronic Arsenic Poisoning

ARSENIC POISONING is still with us, as Dr Gorby has reported elsewhere in this issue, and we need to be vigilant to diagnose it. The features of arsine poisoning and acute poisoning from inorganic arsenic compounds are well defined and easy to recognize, but the features of chronic poisoning from small amounts of inorganic arsenic repeatedly administered are insidious and nonspecific; the patient feels tired and listless and experiences generalized muscle weakness, paresthesia and numbness in the extremities, and anorexia and general malaise. Chronic arsenic poisoning in humans is usually derived from iatrogenic sources, from working in the smelter industry, or from exposure to inorganic arsenic compounds in water supplies (usually domestic water wells).

Fowler's solution (1% potassium arsenite) was used for many years as a tonic and for the treatment of psoriasis and asthma. The prolonged use of this medication produces chronic arsenic poisoning and, although it was withdrawn from use in the 1950s, cases of poisoning still occasionally occur; we reported in 1979 the case history of a patient who presented with hematemesis from esophageal varices that were the consequence of presinusoidal portal hypertension, a known complication of chronic arsenic poisoning.[1] He had been taking an arsenic-containing tonic daily for 55 years and had the obvious dermatologic features of chronic arsenic poisoning; his hair arsenic level was 11.7 parts per million (ppm; normal less than 1). It should be remembered that skin cancer is common in patients with arsenic-induced hyperkeratoses. Arsenic-containing medications are still widely used in herbal remedies in the Far East.

Exposure to inorganic arsenicals, particularly arsenic trioxide and sulfides, may occur in workers employed in the smelting of nonferrous ores, particularly copper and gold, and several studies have reported an increased prevalence of lung cancer (particularly adenocarcinoma) in this industry.[2] Evidence of arsenic toxicity in smelter workers is usually confined to this increased prevalence of lung cancer, but neuropathy has also been reported in this group.[3] Although arsenic has been blamed for many other types of cancer, the only convincing association other than with cancer of the lung is with hepatic angiosarcoma, which may develop many decades after exposure has ceased.[4] There is also some evidence that arsenic may be mutagenic and teratogenic.[2] The study of arsenic carcinogenesis has been confounded by the lack of a susceptible animal model; Pershagen, however, has been able to produce lung cancer in hamsters by the intratracheal injection of arsenic trioxide mixed with charcoal carbon.[5]

Chronic arsenic poisoning may also occur from the continuous ingestion of small amounts of arsenic in domestic well water. Arsenic is widely distributed in natural rock formations, particularly the meguma group of gold-bearing rocks that are found in the northeastern, northwestern, and southwestern parts of the United States and in eastern Canada extending from the Atlantic Coast to the Manitoba border. Normally the arsenic is complexed as the relatively insoluble sulfides, but if the rock is worked and weathered, these compounds can be oxidized to the more soluble oxides and can enter the water supply. Surface water and shallow wells—less than 9 m (30 ft) deep—frequently are self-cleansing. Surface water, particularly when acid, frequently has a high iron content, and this matrix, particularly if it is well oxygenated, promotes the formation of insoluble iron-arsenic complexes that precipitate into the sediments; the lake sediments in eastern Canada can be rich in arsenic, but these appear to be stable. Conversely, deep wells may be heavily contaminated with soluble arsenic compounds as they often are more alkaline, and this reduces the solubility of iron. Also, these waters frequently exist under reducing conditions, and the reduced forms of arsenic and iron (arsenite and ferrous iron) do not co-precipitate to the same extent